

EXPATHEALTH FRANCE

POLICY WORDING

A Morgan Price International Healthcare Ltd Policy

Registered in England No. 3771138, Registered office:
11a Forge Business Centre, Palgrave, Norfolk, IP22 1AP, United Kingdom
info@morgan-price.com www.morgan-price.com



Morgan Price International Healthcare Ltd is authorised and regulated by the Financial Services Authority (FSA) under license number 313738

IMPORTANT

It is essential that you keep this document with you as the information contained will assist you in the event of an emergency. It should be retained to facilitate any claim.

Section 1. DEFINITIONS

The following words or phrases have the meanings given below wherever they appear in your policy documentation from us:

ACCIDENT

means an unexpected, unusual and specific event which occurs at an identifiable time and place.

ACCIDENTAL DEATH

means death caused directly as a result of an accident during the period of insurance.

AREA OF COVERAGE

shall mean the geographical area for which the appropriate premium has been paid.

BODILY INJURY

means identifiable physical injury caused by an accident occurring during the period of insurance.

CERTIFICATE OF INSURANCE

The certificate which details, amongst other things, the Insured persons, level and area of cover, and period of insurance.

CHRONIC CONDITION

A Chronic condition is defined as a sickness, illness, disease or injury which has one or more of the following characteristics:

- is recurrent in nature,
- is without a known generally recognised cure,
- is not generally deemed to respond well to treatment,
- requires palliative treatment,
- requires prolonged supervision or monitoring,
- leads to permanent disability.

CLOSE BUSINESS COLLEAGUE

means an associate of yours in the same employ, whose absence from work necessitates the cancellation or curtailment of the trip as certified by a senior director of the company for which you work.

CLOSE FAMILY RELATIVE

means your spouse, child, parent, brother, sister, parent-in law, grandchild or fiancé(e).

CO-INSURANCE

shall mean the percentage amount payable by you after the deductible amount has been satisfied against eligible medical expenses before we pay our percentage.

COMPLICATION OF CHILDBIRTH

refers to the following conditions that arise during childbirth that require a recognised obstetric procedure; post-partum haemorrhage and retained placental membrane. Where the insured's plan also includes a routine maternity benefit, complications of childbirth shall also refer to medically necessary caesarean sections.

COMPLICATIONS OF PREGNANCY

refers to the following conditions that arise during the antenatal stages of pregnancy; ectopic pregnancy, miscarriage, stillbirth, hydatidiform mole.

DAY CARE

treatment at a hospital where the insured is admitted to a hospital bed, but does not stay overnight.

DAILY CASH BENEFIT

payable where treatment is received in a government or charitable hospital and where no costs are incurred under this policy, and no other claims are made.

DEDUCTIBLE/EXCESS

shall mean the amount payable by you against eligible expenses before we pay any eligible expenses.

DEPENDANT CHILDREN

shall mean a child or children who at the effective date are up to a maximum of 21 years of age (or 25 years of age if disabled or in full-time education) permanently living with and/or financially dependant upon the insured parents.

EFFECTIVE DATE

means the date on which the insurance under this policy commences.

EVACUATION

applies where the necessary treatment for which the insured person is covered is not available locally or if adequately screened blood is unavailable in the event of an emergency. We will evacuate the insured person to the nearest appropriate medical centre. Please note that the nearest appropriate medical centre may not be located in your home country. The medical evacuation will be carried out in the most economical way having regard to the medical condition. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the evacuated member to return to his/her principle country of residence.

HOME COUNTRY

is the country for which the insured person holds a passport. Where more than one passport is held the home country will be considered to be that declared on the proposal form. Where a family is to be included there will be deemed to be one home country, as declared on the proposal form.

HOSPITAL

is any institution which is legally licensed as a medical and surgical hospital in the country in which it is located. It must be under the constant supervision of a resident physician.

ILLNESS

means a medical condition/illness which first manifests itself during the period of insurance.

INPATIENT

treatment where an insured is admitted to a hospital bed for one or more nights.

INSURED/ INSURED PERSON/ YOU/YOURS

persons who are noted in the certificate as persons to be insured (each person is considered to be separately insured).

INSURER/WE/OUR/US

Means Brit Insurance Limited on behalf of Morgan Price International Healthcare Ltd.

MEDICAL EXPENSES

means inpatient, day-care and outpatient fees, hospital room and board, nursing, diagnosis, treatment and surgery fees, operating theatre fees and intensive care charges, doctors, surgeons and specialist fees, anaesthetics, medication, X-ray, physiotherapy, dressings, drugs and medicines on prescription. Also to include road ambulance charges to nearest hospital in an emergency.

MEDICAL PRACTITIONER

a person who has the primary degrees in the practice of medicine and surgery following attendance at a recognised medical school and who is licensed to practise medicine in the country where treatment is given.

MID WIFE FEES

refer to fees incurred by a midwife or birth assistant, who according to the law of the country in which treatment is given, has fulfilled the

necessary training and passed the necessary state examinations.

NEWBORN CARE

includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth. Further preventative diagnostic procedures, such as routine swabs, blood typing and hearing tests, are not covered. Any medically necessary follow up investigations and treatment are covered under the newborn's own policy.

OPTICAL

Includes cover for an annual eye examination by an ophthalmologist, and cover for prescription glasses or contact lenses. It does not cover frames.

OUTPATIENT

treatment including diagnostic procedures, physiotherapy, manipulation when the insured has not been admitted to a hospital bed.

OVERALL ANNUAL LIMIT

is the total aggregate amount that may be claimed in one period of insurance by an insured person.

PALLIATIVE TREATMENT

is treatment provided to offer temporary relief from the presenting symptoms of a medical condition, rather than to cure the actual medical condition causing the symptoms.

PERIOD OF INSURANCE

shall mean the period of time during which cover under this Certificate operates. Unless otherwise stated on the Certificate of Insurance, this will be 12 months from the Effective Date.

PHYSICIAN

is a legally licensed medical practitioner recognised by the law of the country where treatment is provided and who, in rendering such treatment, is practising within the scope of the licence and training.

PRE-EXISTING MEDICAL CONDITION

Is any medical condition (or related condition), which was diagnosed, has required medical treatment (including prescribed drugs), or for which medical advice was sought or for which symptoms have occurred, whether investigated or not, but where the insured person would have reasonably been aware of such symptoms, prior to the insured person's Effective Date.

PRE-NATAL CARE

includes common screening and follow up tests, as required during a pregnancy, amniocentesis for women aged 35 and over and DNA-analysis, if directly linked to an eligible amniocentesis. Triple/bart's or quadruple tests are not covered.

PREMIUM DUE DATE

The date on which a premium or part premium becomes due for payment to us under the policy. This will be in accordance with the following approximate schedule:

- Monthly – every 31 days

- Quarterly – every 91 days
- Semi annually – every 182 days
- Annually – every 365 days

REASONABLE AND CUSTOMARY COSTS

Costs incurred for eligible Medical Treatment and/or supplies that do not exceed the standard fee of other providers of similar standing in the same region, for the same treatment of a similar illness or injury.

*If we determine that eligible costs are above what is considered to be Reasonable and Customary for medical procedures and/or supplies in a given region of the world, then We reserve the right to reimburse only the Reasonable and Customary Costs. An assessment of the Reasonable and Customary Costs will be determined solely by the Assistance Company.

RENEWAL DATE

will be as indicated on the Certificate of Insurance.

REPATRIATION

means the necessary and medically recommended return of an Insured Person to the country for which the passport is held or to the country of residence.

ROUTINE DENTAL TREATMENT

Is defined as examinations, tooth cleaning, normal fillings using amalgam or composite material (NOT GOLD), porcelain crowns and extractions.

ROUTINE HEALTH CHECKS

These are tests/screenings that are undertaken without any clinical symptoms being present. Such tests include the following examinations performed, at an appropriate age interval, for the early detection of illness or disease:

- vital signs (blood pressure, cholesterol, pulse, respiration, temperature etc);
- cardiovascular exam;
- neurological exam;
- cancer screening;
- well child test (for children up to the age of 6 years, up to a maximum of 15 visits per lifetime).

ROUTINE MATERNITY

refers to any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre and postnatal care, mid wife fees as well as newborn care. Costs related to complications of pregnancy and childbirth, are not payable under routine maternity.

TRANSPORT OF MORTAL REMAINS

is the expense of preparation and the air transportation of the mortal remains of the insured person from the place of death to the home country. Cover is not available where death occurs in the home country.

TREATMENT

means surgical or medical intervention or any necessary consultations or diagnostic procedures.

TRIP

means a holiday or journey (not exceeding 31 days) which starts from your country of residence as stated in this certificate and ends on return to your country of residence which is booked during the period of insurance for losses occurring during the period of insurance.

Section 2. BENEFITS

General (Applicable to all benefits sections)

Benefits are payable up to the limits shown within Your chosen level of cover for the reasonable and necessary expenses under each section subject to:

- I. The eligible claims are incurred during the twelve months for which the Premium has been paid, and submitted within 6 months of incurring the loss. The Insurer is entitled to refuse to make payment if:
 - the premium has not been paid
 - the claim was not incurred within the period of the insurance contract
 - the claim was not submitted within 3 months of incurring the loss
- II. Benefits payable in any currency other than sterling which require conversion will be converted at the current exchange rate as negotiated by the administrators.
- III. Benefits will be payable in accordance with information supplied on the claim form.
- IV. Territorial limits under this insurance are arranged in 3 geographical areas of cover. The Insured Person will select at inception or renewal, the relevant area of cover. Full benefits will be available within the selected area of cover, or any lower area of cover whilst travelling on holiday, or business trips.

Section A. Medical Benefits

Benefits are payable up to the limits shown within Your chosen level of cover for the reasonable and necessary Medical Expenses if an Insured Person shall sustain Bodily Injury or shall suffer Illness, such expenses to be medical, surgical and specialist's fees, hospital, physiotherapy and manipulative treatment, surgical and medical requisites and the cost of medically necessary repatriation/evacuation subject to:

1. The policy has a two year moratorium. This means that pre-existing conditions will not be covered during the first two years of the policy, after which a pre-existing condition will be covered if a period of two consecutive years has elapsed during which the insured had no symptoms and received no treatment, medication, tests or advice in respect of the condition.
2. The treatment was given by or under the control of a qualified Medical Practitioner.
3. Routine Maternity benefit will be payable after the first twelve months following the effective date where maternity benefits are included in the chosen level of cover. Complications of pregnancy and childbirth (as defined) are also paid after the first 12 months following the effective date up to the overall annual limit stated in the benefits table.

A caesarean section is deemed by us to be complicated maternity only if a normal delivery was planned and fully expected in good faith, but a complication intervenes and a normal delivery is no longer appropriate. When such an event occurs, cover will be provided up to the limit specified in your Table of Benefits, for Complicated Maternity Care. Where the requirement for a caesarean section was predictable in advance (e.g. twins/triplets, breech/shoulder/face/brow presentation, placenta praevia, eclampsia or pre-eclampsia, maternal diabetes, etc.), it would not be considered by us as Complicated Maternity Care. In addition, caesarean sections planned in advance of labour because of a previous caesarean section etc., are not considered by us to be Complicated Maternity Care. In such instances, cover will be provided up to the limit specified in your Table of Benefits, for Routine Maternity. 4. Whilst You can have treatment in another country within Your chosen area of cover (or lower area of cover), this will only be permitted with the prior notification of, and written instruction from the Morgan Price Claims Department.

Benefits payable will be limited to reasonable and customary charges for the relevant treatment within Your chosen area of cover, and will be determined by the Morgan Price Claims Department.

5. Home Nursing benefit will be available immediately following treatment as an in-patient or day-patient and only on the recommendation of a Specialist. This benefit must be provided by a Qualified nurse (of a standard recognised by us), and is limited to the period shown under your chosen level of cover.

6. Parent accommodation benefit is available where a parent is staying overnight in hospital with another insured person being a child under 18 who is admitted as an in-patient to a hospital for treatment.

7. Psychiatric treatment under this policy will only be available if it is pre-authorized in writing by us prior to any costs being incurred. Any psychiatric treatment provided must be administered by a recognised Psychiatrist.

8. Under the Organ transplant benefit, costs will only be payable for an Insured Person under this scheme, and not for any donor, costs of locating and removing the replacement organ, or transport and administration costs associated with the donor and donor organ.

9. Routine dental treatment is available (where listed in the benefit schedule) providing that an insured person a) has a normal registered dentist, and b) has visited that dentist within the 12 months prior to the effective date (or renewal date) of the policy. Costs incurred within the first 3 months of the effective date of the policy under this benefit are excluded.

10. Routine health checks are available to members who have completed a continuous period of 24 months cover with us. The tests covered are detailed under the definitions section. Please contact the helpline prior to incurring any costs under this benefit to check eligibility.

Section B. Optional Medical Benefits

1. Treatment for Chronic conditions newly diagnosed after the effective date of the policy will be covered to the limit stated in the endorsement, where this cover is selected. Cover will be extended to include the routine management and palliative expenses incurred in connection ONLY with a new chronic medical condition. This benefit is limited to a

maximum of £15,000 per insured person, for the entire duration of the policy (not per annum), and is dependant on the policy being maintained in force for the entire duration of the claim.

The benefit will include routine check ups, drugs prescribed for the management of the condition, hospital accommodation, nursing fees, surgery and any palliative treatment supplied.

2. Treatment for Human Immuno-Deficiency Virus (HIV) and or HIV related illnesses including Acquired Immune Deficiency Syndrome (AIDS) or any related derivatives or variations, newly diagnosed after the effective date of the policy will be covered to the limit stated in the endorsement, where this cover is selected. Cover will be extended to include the routine management and palliative expenses incurred in connection ONLY with a new HIV, Aids or related condition. This benefit is limited to a maximum of £15,000 per insured person, for the entire duration of the policy (not per annum), and is dependant on the policy being maintained in force for the entire duration of the claim.

The benefit will include routine check ups, drugs prescribed for the management of the condition, hospital accommodation, nursing fees, and any surgery required.

Section 3. GENERAL CONDITIONS

(Applicable to all benefits sections)

1. The contract

The schedule of benefits, the policy wording, the proposal form and any endorsements issued form part of the contract and should be read together as one.

2. Legal proceedings and applicable law

You shall not institute any legal proceedings to recover any amount under the policy until at least sixty days after the claim has been submitted to us and not more than two years from the date of this submission unless otherwise required by mandatory legal regulations. The policy shall be construed in accordance with English law, unless agreed otherwise between you and us, or required under mandatory legal regulations.

3. Due care and attention

The Insured shall at all times act in a prudent manner and shall exercise reasonable care to prevent accidental injury or illness.

4. Claims and dispute

All claims shall be considered fairly under the terms of the insurance and all such decisions shall rest solely with the Insurer. Any differences in respect of medical opinion in connection with the results of an Accident or illness will be settled between two medical experts appointed by the two parties to the dispute in writing. Any difference of opinion between the two medical experts shall be referred to an umpire who shall have been appointed in writing by the two medical experts at the time of their appointment.

5. Making a claim

Original documentation, supporting invoices and receipts and a fully completed claim form must be submitted when making a claim (copies are not acceptable). The claim form must be completed by the treating physician or specialist. A claim form is not acceptable when completed by a physiotherapist, osteopath or chiropractor or any practitioner not qualified to practice in medicine. The Insured is advised to contact the Morgan Price Claims Department prior to treatment or hospitalisation to determine eligibility of this benefit.

6. Payment of claims and subrogation

- a. The Insurer is entitled to delay payment of a claim to determine validity, or to request the Insured to furnish them with any necessary additional information or consents, or to examine the Insured whose accidental injury or illness is the subject of the claim at their own expense, or in the event of death to have a post mortem undertaken at their own expense where this is not prohibited by law.
- b. The Insurer must be advised if the Insured can make a claim on any other insurance policy, e.g. a third party claim, Government department, and the like. The Insurer has full rights of subrogation.

7. Alterations to policy terms

The Insurer is entitled to alter all or any part of the wording and the benefits or to terminate the plan. Notification will be sent to the Insured's last known address and the change will take effect from the next renewal date.

8. Eligibility

The insurance is available to anyone up to the age of 74 years at the expiry of this insurance. Children can be covered immediately from birth provided we are notified within 30 days of the birth date and subject to payment of the appropriate premium.

9. Material risk

If You or any Insured Person regularly engage in any occupation, sport, pastime or other activity in which materially greater risk may be incurred than previously disclosed in connection with this plan You must notify the Insurer and obtain written agreement to the inclusion under this plan.

10. Emergency Assistance

The International emergency assistance and claims administration services will be provided by Cega Air Ambulance Limited on behalf of Morgan Price International Healthcare Ltd and all repatriations/evacuations/return of mortal remains will be at the sole discretion of Cega Air Ambulance Ltd and no other assistance provided by any other company will be considered a covered benefit.

11. Policy duration and premium payment

- (a). This is an annual contract which is renewable each year subject to the terms and conditions in force at the renewal date and subject to the applicable renewal premium.
- (b). All premiums are payable in advance of cover being provided under this policy.
- (c) Premiums are payable monthly, quarterly, semi annually or annually but this is an annual contract of insurance, so you are still responsible for paying the entire annual premium even if we have

agreed you may pay by instalments. If we do agree you can pay by instalments then you must ensure the credit card you supply is valid for the entire period of the policy year.

- (d) We reserve the right to withdraw frequency payment facilities and/or charge an administration fee for non-payment.
- (e) The policy will be cancelled if a payment date is missed although we may subsequently reinstate cover if an outstanding payment is received within 30 days of its due date.
- (f) If we do reinstate cover we reserve the right to reapply exclusion 1.
- (g) IMPORTANTLY – if a premium is outstanding, any claims will be suspended and will not be settled until the premium is paid up to date.
- (h) If any premium is unpaid at the end of this 30 day period, and the policy is cancelled, it will be cancelled from the date that the unpaid premium is due. Any outstanding premium will be deducted from any valid claim in progress, or will be deducted from the credit card or debit card supplied.
- (i) Premiums are payable in the currency of the policy which you elected at the effective date of the policy.
- (j) We reserve the right to alter premiums at any time but if we do so the new premiums will not be effective until your renewal date.
- (k) We reserve the right to alter the amount of Insurance Premium Tax, government levies or other taxes as and when they change by law and to apply them at the next premium due date.

12. Cooling off period

- (a) The policyholder may cancel the policy within 14 days of the effective date. If you have not made a claim on the policy we will refund your premiums paid in full.
- (b) If you have made a claim then we will refund your premium after deducting a charge for the cover provided from the beginning of the contract until the policy is cancelled

13. Cancellation

- (a) If the policyholder wishes to cancel the policy at any other time you must give us notice in writing at the address shown on the policy documentation. We will cancel the plan 14 days from the date of receipt of such instruction or from a future date – under no circumstances will we backdate any cancellation.
- (b) All membership cards and policy certificates must be returned to us with your cancellation notification and then a pro rata refund may be applicable provided no claims have been made in the current 12 month policy period. If a claim has been made, then no refund will be payable.
- (c) If you cancel your plan we reserve the right to charge an administration fee of £30;
- (d) We will not cancel this policy because of eligible claims made by any Insured Person. However we reserve the right to cancel the policy at any time if any Insured Person has:
 - (i) Misled us by mis-statement or concealment; or
 - (ii) Made or attempted to make a false or fraudulent claim or if any person uses any methods to try to make a fraudulent claim; or
 - (iii) Fails to act with utmost good faith; or
 - (iv) Fails to pay the appropriate premium.

14. Other insurance

If there is any other insurance covering the same benefits as provided for under this policy, you must disclose the same to us, and we will not be liable for more than our rateable proportion.

15. Change of cover level

You may change your level of cover and/or any voluntary excess/deductible at your next renewal date. Such changes will apply for the following annual period of cover.

16. Change of area of cover

You may change your area of cover at any time. Such change will be effective from the date we are notified subject to the payment of any additional premium due. Such changes will apply to the remainder of your policy year.

17. Renewal

- (a) We will invite you to renew your plan each year. We will ordinarily do this by email unless you have contacted us to ask for a different method.
- (b) You are obliged to ensure that we have current contact details for you (in particular if you have changed your email address during the year) at all times but especially at the renewal date since without these we cannot contact you and your cover may lapse.
- (c) The premiums applicable and the benefits in force may be altered at each annual anniversary but we will advise you of any changes in advance.
- (d) Your obligations to disclose any changes to material facts reappplies at each renewal, since each annual period of insurance is a separate contract between you and us.
- (e) If you pay your premiums by credit card and the card we hold is still valid at renewal, then your plan will be renewed on the anniversary date at the new rates applicable – this means we will automatically debit the card with the applicable payment. If the payment is not accepted by your card issuer then the policy will be suspended and we will attempt to contact you. If we cannot contact you within 30 days of the renewal date then the policy will be lapsed from the renewal date and any claims made after the renewal date will not be valid.
- (f) If you do not want to renew your policy you MUST contact us and advise us of this prior to the renewal date shown on your current Certificate of Insurance.

Section 4. EXCLUSIONS

(Applicable to all benefits sections)

Benefit is not payable for:

1. Pre-existing conditions during the first two years of the policy. After this moratorium period, a pre-existing condition will be covered if a period of two consecutive years has elapsed during which the insured had no symptoms and received no treatment, medication, tests or advice in respect of the condition.
2. The deductible/excess amount of any claim (where applicable).
3. General health or well person checks and eye or dental examinations, vaccinations, prescribed drugs and dressings, except where shown in the benefits schedule.

4. Hospitalisation, including rehabilitation, which is not directly connected to the treatment, or which is for social or domestic reasons.

5. Spa or hydro treatment, rest cures, long term care, sanatorial or custodial care or periods of quarantine or isolation.

6. Cosmetic or aesthetic surgery.

7. Organ transplant surgery, including bone marrow, and any related treatment, except where shown in the benefits schedule.

8. Cryopreservation and any connected costs.

9. Maternity claims, including complications of pregnancy and childbirth, except where shown in the benefits schedule. Where covered, maternity claims in respect of pre and postnatal classes as well as triple/bart's or quadruple tests are not covered.

10. Psychiatric conditions except as shown in the benefits schedule.

11. Products that can be purchased without a doctors prescription.

12. Products classified as vitamins or minerals (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), nutritional or dietary supplements, including cosmetic products, even if medically recommended or prescribed or acknowledged as having therapeutic effects.

13. Prescribed physiotherapy refers to treatment by a registered physiotherapist following a referral by a medical practitioner.

Physiotherapy is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as Roling, Massage, Acupressure, Milta therapy and Kineseotherapy carried out by a non registered physiotherapist.

14. We do not cover psychotherapy and counselling.

15. We do not cover conditions such as conduct disorder, attention deficit hyperactivity disorder, oppositional defiant disorder, antisocial behaviour, obsessive-compulsive disorder, attachment disorders, adjustment disorders, as well as treatments that encourage positive social-emotional relationships such as communication therapies, floor time, and family therapy.

16. Congenital and birth defects and deformities in respect of children under three years of age.

17. Dental treatment, except as shown in the benefits schedule.

18. Attempts at suicide, whether successful or not, or any self inflicted injury.

19. Illnesses once they have been diagnosed as either chronic or terminal except where newly diagnosed after the policy effective date and where optional cover for chronic conditions was selected at the time when policy was first taken out with Morgan Price as shown in the benefits schedule.

20. Spectacles, contact lenses, hire of medical/surgical equipment, prostheses (except when required intraoperatively) and appliances (except when required intraoperatively), except as shown in the benefits schedule.

21. Treatment and investigations of allergies, impotence and fertility/infertility, including sterilisation and reversal of sterilisation.

22. Medically assisted reproduction or any consequence thereof.

23. Treatment required during the first 3 months after birth for any child born as a result of medically assisted conception other than artificial insemination.
24. Treatment of sexually transmitted disease.
25. Treatment of any illness or disability which arises in any way from the HIV infection and the AIDS virus.
26. Treatment which is in any way connected to sex change.
27. Illnesses and accidents and the consequences thereof, as well as instances of death, that are caused by the misuse or alcohol or drugs by the insured person, or by substance abuse of any kind.
28. Treatment of any development delay and/or learning disability.
29. Treatment of long or short sightedness.
30. The use, or any treatment therefrom, of any drugs not licensed by the official government control agency of the country in which the drug was given, or drugs used in any circumstances other than in accordance with their licensed indications.
31. Treatment which is not scientifically recognised by the official government control agency, or is not established or customary, excessive or medically inappropriate for the illness or injury concerned.
32. Treatment for which the insured has travelled specifically outside the area of coverage, or travelled against medical advice.
33. Any occupation, sport, pastime or other activity, in which a materially greater risk may be incurred in connection with this plan.
34. Treatment resulting from the Insured persons active participation in war, riot, civil commotion, or other illegal acts.
35. Compensation other than on a proportionate basis if the Insured Person or any other person covered under this insurance has any other insurance in force or is entitled to indemnity from any other source in respect of the same Bodily Injury, sickness, disease, death or loss. The insurers have full rights of subrogation.
36. Costs not incurred within the period of insurance and claims submitted later than 3 months after they were incurred.
37. Charges for care or treatment by a family member, including prescription of drugs.

Section 5. Claims procedures

1. For claims involving a Medical Emergency

To ensure that you and your family members receive quality support and assistance in the case of an emergency, where possible, you should contact our Helpline within 48 hours of the event. Our 24 hour Helpline can provide you with a wide range of assistance services, from identifying an English-speaking doctor through to arranging a full medical evacuation.

Pre Authorisation for hospitalisation (refer to Pre Authorisation section below) is not required in emergency cases, however, we should be advised within 48 hours of the event. This will ensure that your claim is processed quickly and will also give us an opportunity of settling directly with the provider for the treatment received.

You can contact us by phone 24 hours a day, on the following Helpline number: **Morgan Price Emergency Assistance: +44 1243 621567**

2. For Non-emergency Medical Claims

Please follow the guidelines below to help us process your claims promptly and efficiently.

All claims should be submitted to us with original supporting documentation, invoices and receipts within three months of the treatment date or within 3 months after the end of the insurance year whichever is sooner.

Before you make a claim, it is important to ensure that your plan covers the treatment you are seeking (e.g. out-patient, maternity, dental etc.). Our Helpline staff would be happy to assist with any queries you may have, you can contact our claims department on the following number:

Morgan Price Claims: +44 1243 621224

2.1. In-patient claims.

In the event of hospitalisation, we will, where possible and with sufficient notice, arrange for direct settlement with providers subject to any co-payments, excess/deductibles and benefit limits.

Our claims department should be contacted prior to commencement of treatment by your physician to have you treatment approved over the telephone. Unless it is an emergency you must contact us at least five working days prior to receiving treatment. We can then ensure there will be no delays at the time of admission and we can advise you regarding cover for your condition.

2.2 Out-patient or dental claims.

Please note that psychiatric treatment and certain other treatments, will need to be pre-authorised with our claims department by your physician prior to the treatment taking place.

Please note that the incurred costs will be reimbursed within the limits of your policy, after taking into consideration any required Pre Authorisation and will be net of any deductibles or co-payments.

Unless you have been informed of a different settlement arrangement, out-patient or dental treatment is generally paid for by the patient at the time of receiving treatment and the costs incurred are then recovered from Morgan Price International Healthcare Ltd.

We recommend the following steps in making an out-patient or dental claim:

- Whenever you visit a general practitioner, dentist, physician or specialist on an out-patient basis, please make sure you take a Claim Form with you.
- Fill in the section that is assigned to you, then date and sign the Claim Form.
- Make sure that your doctor provides all relevant medical information in the specified section and then dates, signs and stamps the Claim Form. However, if you are in Germany or the USA, or if your invoices contain

details of the diagnosis as well as the nature of the treatment, there is no need for your treating doctor to complete this section of the Claim Form.

- Attach all original supporting documentation, invoices and receipts to the Claim Form (e.g. general practitioner/physician invoices, pharmacy receipts with related prescriptions (if available)), and post to the Morgan Price Claims Department at the address indicated on your Claim Form.
- If the amount to be claimed is less than the deductible figure under your plan, remember to retain the claim form and receipts - do not destroy or dispose of them. Keep collecting all out-patient receipts and claim form documents until you reach an amount in excess of your plan deductible. Then forward to us all completed Claim Forms together with original receipts/invoices.
- Remember a separate Claim Form will be required for each person claiming and for each medical condition being claimed for.
- Specify on the Claim Form the currency in which you wish to be paid, otherwise the benefit due to you will be paid in the currency of the invoice.
- Please note that the incurred costs will be reimbursed within the limits of your policy, after taking into consideration any required Treatment Guarantee and will be net of any deductibles or co-payments mentioned in the Table of Benefits.

You can download the Claim Form from our web site
www.morgan-price.com

All documentation should be sent to:

Morgan Price Claims Services
PO Box 127
Chichester
West Sussex
PO18 8WQ

Morgan Price Emergency Assistance

Telephone: +44 1243 621567 Fax: +44 1243 773169

Email: mp-assistance@cegagroup.com

Morgan Price Claims

Telephone: +44 1243 621224 Fax: +44 1243 790265

Email: mp-claims@cegagroup.com

3. Pre Authorisation

3.1 What is Pre Authorisation?

Pre Authorisation must be obtained by your physician from our claims department for approval prior to treatment.

3.2 When is Pre Authorisation required?

Pre Authorisation is required for the following:

- in-patient treatment
- MRI (Magnetic Resonance Imaging) and PET (Positron Emission Tomography) scans,
- nursing at home,
- medical evacuation or repatriation,
- repatriation of mortal remains.

3.3 Why is Pre Authorisation required?

In the case of planned hospitalisation, Pre Authorisation gives us an opportunity prior to your admission, to communicate with the hospital to facilitate smooth admission and guarantee direct payment.

This process will ensure that your hospital stay is free from financial worries, allowing you to concentrate on getting better.

3.4 What happens if I don't obtain Pre Authorisation?

In the event that Pre Authorisation is not obtained for any psychiatric treatment or in-patient treatment or for any other treatment or benefit for which this service is a requirement, we reserve the right to decline a claim. If in the aftermath the treatment is proven medically necessary we will pay only 80% of the in-patient expenses and 50% of the eligible amount for all other benefits mentioned above. In the case of an emergency we should be informed within 48 hours of the event to avoid any Pre Authorisation penalty being applied.

Section 6. Complaints Procedure

If you have a complaint or if you are unhappy with any aspect of our service, please e-mail, telephone or write in the first instance to

The Managing Director
Morgan Price International Healthcare Ltd
11a Forge Business Centre
Palgrave, Norfolk, IP22 1AP
Telephone: +44 (0)1379 646730
Email: info@morgan-price.com

We will acknowledge receipt of it within 5 working days.

If we do not resolve your complaint to your satisfaction, please e-mail, telephone or write in the second instance to:

Complaints Department
Brit Insurance Limited
55 Bishopsgate
London EC2N 3AS
Telephone: +44 (0)20 7098 6509 Fax: +44 (0)20 7984 8473
Email: complaints-team@britinsurance.com

If we do not resolve your complaint to your satisfaction, or if we are unable to give you a final response within 8 weeks of our acknowledgement to you, you may contact the Financial Ombudsman service at:

South Quay Plaza, 183 Marsh Wall, London, E14 9SR
Or contact them on +44 (0) 207 964 1000
(or from within the UK 0845 080 1800)